

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001963

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED JAN 22 1963

146

4237

35

VS 300
Rev. 4/59

17003

27003

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94201

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1290-0

131-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Raytown		Length of stay in 1b 3 mo.	c. CITY OR TOWN Raytown Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6140 Raytown Rd.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6140 Raytown Rd Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Claudia M. Bergstrom		4. DATE OF DEATH Month 1 Day 9 Year 63	
5. SEX Fe	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-10-95
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	9. AGE (last birthday) 67 IF UNDER 1 YEAR Months Days Hours Min.
11a. FATHER'S NAME Matthew E. Pearson		11b. MOTHER'S MAIDEN NAME Carrie Davis	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) no		12b. SOCIAL SECURITY NO. Carl M. Bergstrom, Raytown Mo.	
13. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. coronary artery disease DUE TO (b) 2 hrs. DUE TO (c) 6 mo		14. NAME OF HUSBAND OR WIFE Carl M. Bergstrom INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Sept. 1962 to Jan. 9, 1963 and last saw her/him alive on Jan. 9, 1963 Death occurred at 11 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE E. J. Burk MD (Degree or title)		22b. ADDRESS 5140 Antioch Rd. A.C. 19 Mo.	
22c. DATE SIGNED 9 Jan. 63		22d. LOCATION (City, town, or county) Kansas City, Kansas	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 1-12-63	23c. NAME OF CEMETERY OR CREMATORY Highland Park	
23d. FUNERAL DIRECTOR Gibson & Son, Kansas City, Kan.		23e. DATE RECD. BY LOCAL REG. 1-12-63	
23f. REGISTRAR'S SIGNATURE Alba L. Craig			

USE BLACK INK
OR
TYPEWRITER RIBBON

PROFESSIONAL CERTIFICATE

DECEASED

DATE OF DEATH

AGE

1003
1003

1-18-63

4

0-31

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Phil Gibson

Licensed Embalmer No. 3135

P. O. Address Kansas City, Kansas

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.